VOL. 14, NO. 2 JULY-AUGUST, 1964

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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RALEIGH, N. C.

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WHAT WE SAY VS WHAT WE DO

BY JOAN K. JACKSON, Ph.D.

IT has been almost ten years since the American Medical Association made a formal statement to the effect that alcoholics are sick people and that alcoholism is a disease. By so doing they officially put a stamp of approval on a concept long held by people who had worked intensively with alcoholics. Alcoholics Anonymous had considered alcoholism as a kind of disease since the organization began, and they had borrowed a concept which was already old.

With this kind of history it would have been anticipated that physicians, the general public, the families of alcoholics and alcoholics themselves would accept alcoholism as an illness. Indeed, there is some evidence that they do. Surveys of public opinion have found that when people are asked to say whether they think alcoholism is illness or crime, they tend to choose illness as the most appropriate descriptive term. When they are asked what should be done about alcoholics, they tend to suggest Alcoholics Anonymous (or AAA which, in America, is the American Automobile Association) or medical treatment and to be against incarceration.

Yet, when we examine what actually happens to alcoholics during exacerbations in their illness, it is legitimate to question whether the public pays more than lip service to the concept that alcoholism is a disease. Alcoholics are still accepted by judges and jails more frequently than by physicians and hospitals. Their families are considerably more likely to suggest that alcoholics go to H— than to a doctor! Even members of Alcoholics Anonymous do not behave in a manner consistent with their stated conviction that the alcoholic is a sick man. They tend to convey a marked skepticism about the usefulness of medical treatment for alcoholics and to define the role of the physician almost entirely in withdrawal terms, i.e., treat the withdrawal symptoms and withdraw from the case.

Thus, at present we have a situa-

tion in which there is widespread agreement on a verbal level that the alcoholic is sick, but in which everyone (including the alcoholic himself, those who live with him and those who treat him) behaves as if he were not ill. Such a situation is, if anything, worse than the one which it superseded. At least before, the alcoholic was sure that he knew what the nature of his problem was, even though his certainty was an illusion. Now we find that the alcoholic, who was never renowned for his clear thinking about alcoholism, has a sense of compounded confusion about his condition and about what might be done about it. The confusion which the alcoholic feels is constantly reinforced by others who are inconsistent in their behavior toward him as a result of their own uncertainty about the implications and ramifications of the concept of alcoholism-as-illness.

As the lack of congruity between our stated views about the nature of alcoholism and our behavior toward alcoholics has extremely serious consequences for alcoholics, for those who live with them, for those who treat them and for those who try to understand the etiology, course and resolution of alcoholism, it behooves us to define clearly what we mean when we say alcoholism is an illness. This is not as easy to do as it would first appear. Partly this is because of the route we traveled before coming to the understanding of alcoholism's equivalence to other chronic disease.

Historically, we have decided whether or not disease exists in an individual on the basis of unusual physical feelings and behavior which are more than transient, which fall into a pattern a doctor can recognize as having been experienced by others and from which he can predict

The present situation with regard to alcoholism is widespread agreement on a verbal level that the alcoholic is sick with the same people behaving toward him as if he were not ill.

This article was written especially for the New Zealand *Al-Anon Family Groups Magazine* and is reprinted in *Inventory* by permission of the author. Dr. Joan K. Jackson, research associate professor of psychiatry (sociologist) at the University of Washington School of Medicine, is noted for her research studies on many aspects of alcoholism.

what will happen next to these symptoms. However, in every illness, whether it be an acute or chronic illness, the physical symptoms and dislocations do not occur in isolation but, rather, in a context of psychological and social suffering as well. We have tended to look away from these or to dismiss them as being caused by the physical disorder. In recent years there is a vast accumulation of evidence which suggests that the relationships are considerably more complicated than simple cause and effect. In order to diagnose disease at all, there has to be an underlying concern in society for the welfare of individuals, a belief that suffering is undesirable and should be relieved if this is possible.

In the case of alcoholism, however, although it has been manifestly clear down through the ages that there is physical suffering, psychological anguish and social catastrophe experienced by the person who is the al-

(Continued on page 6)

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: Mrs. Pauline Woods, health educator from Durham, N. C., has recently joined the staff of the Education Division, N. C. Department of Mental Health. A recipient of a B.S. degree in health education from N. C. College in Durham, Mrs. Woods also earned her Masters Degree in Public Health Education from the same institutiton. Before joining our staff, she taught in the Pitt County and Orange County Schools. We welcome Mrs. Woods to our staff and hope her stay with us will be long and pleasant.

CRUSADE AGAINST ALCOHOLISM: Recent reports from Colorado and California indicate an increasing awareness by U. S. Army officials of the personnel problems caused by alcoholism. Fitzsimmons General Hospital in Denver has recently established a Commander's Council on Alcoholism and has set up procedures for handling acute and chronic alcoholism at the hospital. A Commander's Council has likewise been established at Fort Ord, California. Members include a commanding officer, provost marshal, chaplain, advisors from the fields of medicine and psychiatry, the American Red Cross, an AA representative and the Monterey Peninsula Council on Alcoholism.

DETROIT, MICHIGAN: Young people attending the seventh International Conference of Young People in Alcoholics Anonymous in Detroit on June 18 heard Tom Ivester, a supervisor in the alcoholic rehabilitation division of the N. C. Prison Department, speak on the activities of his department. There are, at present, forty-three active prison AA groups in North Carolina—the largest number in any state in the nation.

NEW BRUNSWICK, NEW JERSEY: Research into drinking and driving, especially as related to accidents and fatalities, will be undertaken by the Rutgers Center of Alcohol Studies with a grant of $35,000 from the United States Brewers Association, Inc. The grant will cover the first year of a five year program. Principal researchers in the new study will be Dr. Selden D. Bacon, director of the Center, and Dr. Leon A. Greenberg, director of the Center's laboratory research.

It is hoped that the study will reveal more about the patterns of relations between drinking and driving and answer such questions as, "Are certain types of drinkers or drivers responsible for most of the accidents?" and "Are there particular kinds of circumstances in which these accidents are most likely to occur?" The Center also wants to explore the attitudes of various segments of the public, including law enforcement officers, about drinking before driving and their attitudes about controls.

According to Dr. Bacon, the purpose of the study is to "develop relevant knowledge and make possible greater understanding which will be available to policy makers, educators, and administrators."

WAYNESVILLE, N. C.: One-hundred physicians from nine states gathered together recently for the 11th annual Mountaintop Medical Assembly in Waynesville. One of the lecturers at the meeting was Dr. John Ewing, acting head of the University of North Carolina Department of Psychiatry, who spoke to the group on the general practitioner's role in the treatment of alcoholism. Dr. Ewing stated that there are between 80,000 and 100,000 alcoholics in North Carolina who are sick and who need help. This means that there are 15 or 20 alcoholics per doctor in the state and 300 per psychiatrist. Physicians can help those alcoholics who honestly want help, Dr. Ewing said, by helping them to arrest, not cure, their illness—the same as the illnesses of diabetics and arthritics are arrested—but not really cured. Since the alcoholic can't actually be cured, he can never go back to drinking safely, he concluded.

LAKE JUNALUSKA, N. C.: Lake Junaluska was the scene of the 17th annual State Convention of Alcoholics Anonymous June 19-21. Approximately 1,000 A. A. members and their families gathered together to enjoy the good fellowship and interesting program which had as its theme, "Alcoholism: A Family Problem—Alcoholics Anonymous: A Family Project."

CHAPEL HILL, N. C.: The problem of the alcoholic in marriage is discussed in **Marriage Counseling in Medical Practice,** a book recently published by the University of North Carolina Press and edited by Ethel M. Nash, M.A.; Lucie Jessner, M.D.; and D. Wilfred Abse, M.D. Dr. Ewing, acting chairman of the University's Department of Psychiatry, says in his chapter on "Counseling Help for the Alcoholic Marriage" that there are not just alcoholic men or women but alcoholic marriages which may actually be perpetuating the alcoholism problem. Recently, counselors and physicians have been experimenting with indirect treatment of alcoholics by setting up group therapy sessions for their spouses. It seems to be beneficial for these persons to meet together often to discuss problems they have in common. As a result, some become more tolerant of their alcoholic mates as they come to understand better the problems involved in the illness of alcoholism. With the guidance of a physician, this type of therapy has proved to be very successful, Dr. Ewing reports.

LEXINGTON, KENTUCKY: According to Dr. Carl F. Essig of the National Institute of Mental Health's addiction research center at Lexington, Kentucky, there is evidence of some persons becoming addicted to several of the "tranquilizing" drugs by taking larger doses than doctors prescribe. And, even ordinary doses of the drugs—when combined with drinking alcoholic beverages—can intoxicate some persons.

Dr. Essig pointed out that this might become an increasingly important public health problem unless doctors remain on the alert and added that an abrupt withdrawal of large doses of the tranquilizers has been associated with the death of some patients.

RAYMOND G. McCARTHY

We were all saddened to hear of the death of Raymond G. McCarthy, professor of education and director of the Rutgers Summer School of Alcohol Studies, on June 25. Mr. McCarthy was recognized as an outstanding educator in the field of alcohol and alcohol problems. In addition to serving as associate editor of the **Quarterly Journal of Studies on Alcohol,** he was co-author of the book, **Alcohol and Social Responsibility** and served as editor of many other books. Teaching aids developed by Mr. McCarthy are employed extensively in the nation's classrooms, and his booklet, **Facts About Alcohol,** written especially for teenagers, has been reprinted many times. At the time of his death, he was serving as president of the North American Association of Alcoholism Programs. We have all lost a good friend and the field of alcohol education has lost an energetic, hard-working educator. His contributions were many and the void left by his death will be hard to fill.

CONTINUED FROM PAGE 3

coholic, society has focused only on the social aspects of the behavior, and then only on the impact of that social behavior on other people. The results have been that society has considered that the person who engaged in the destructive social behavior was a "bad" person, has ignored the physical and psychological symptoms, and has tried to control him in the same ways it uses to control other "bad" people. No one was in the least interested in the person who engaged in the behavior or in his suffering. Society was concerned only that the behavior be brought to a stop. Such questions as whether the quantity of intake of alcohol was related to the "badness" of the behavior, and whether the individual drank because he wanted to or because he had to were totally irrelevant and never arose. A person could drink himself to death without society noticing it as long as he did it like a gentleman and had provided for his family first.

Point of View

Thus it is largely to our traditional point of view, rather than because of something inherent in the condition, that alcoholism has been defined as a moral issue while, for example, rheumatism has been looked upon as physical illness. By definition, when there is a moral problem it is necessary to consider the extent to which the person is responsible. When physical illness is thought to exist, personal responsibility is not considered.

It is on this issue of responsibility that we flounder when we try to conceptualize alcoholism in modern, realistic terms as different only in symptomatology, not in quality, from other types of chronic illness. There seems to be the fear that if alcoholism is regarded as illness and, hence, the alcoholic is no longer held responsible for his behavior, he will say he cannot help drinking because he is sick and will remain ill. If I were to use the same reasoning about a person with an ulcer or a chronic heart disorder, you would say, "Come now, that's not at all the same thing!" I would ask you to consider whether it is or not. Such a statement when applied to the alcoholic assumes that he enjoys his illness more than the ulcer patient enjoys his; it assumes that if he had any real certainty of being relieved of his inability to control his drinking he would not take that opportunity. "But," you say, "he knows for certain how to get well. All he has to do is to control his drinking (or stop drinking entirely) and he will no longer be alcoholic." And this is true. The problem is that his illness is not his drinking nor his behavior when drinking per se. His illness is his *inability to control his drinking* or *his inability to abstain.* Thus, to say that he will no longer be alcoholic if he controls his drinking or abstains is the same as saying the ulcer patient will not have an ulcer if he stops ulcerating. Again, our traditional point of view obstructs objective thinking.

"But," you will say, "the ulcer patient doesn't go out and deliberately engage in behavior which he knows will give him an ulcer. The alcoholic deliberately engages in behavior he knows may lead to alcoholism." And I ask again whether there is any difference between the behavior of the person who develops an ulcer and the one who develops alcoholism. Both engage in behavior known to lead to pathological reactions in some people and both are

among the people who react pathologically. Once the disease has occurred, in both cases control has been lost. From that point onward both have the choice only of whether to remain ill or to undertake the drastic changes in life adjustment which will be necessary to recover.

"But," you say, "the ulcer patient doesn't deny that he is sick. He knows he can't control his ulcer and he doesn't try. He just tries to do the things that will stop the ulcer. The alcoholic won't even admit he has a problem." While I shall concede the point for the ulcer patient, denial is a common aspect of many other chronic illnesses. I have worked with many tuberculosis patients who failed to recognize the nature of their illness for years because of rationalizations very similar to those used by alcoholics. They knew they coughed, but felt this was due to their smoking. They knew they perspired at night, but this was because of too many blankets. They coughed spots of blood on occasion but this was due to having fallen recently, etc.

Removal of Stigma

The alcoholic is motivated to deny his illness even more than the person with tuberculosis. Given society's views of what it means to be alcoholic, admission of illness is tantamount to admitting one's total failure as a human being. When the stigma is removed from alcoholism, denial will be less commonly found and of shorter duration. The denial is much more a result of our condemnation of the illness than it is of the illness itself. Indeed, there is considerable evidence to indicate that even with as little change in attitudes toward alcoholism as has occurred up to now, denial is less intense and of shorter duration. Oregon, one of our states with an excellent educational program, claims that this changed attitude is the reason for their alcoholics' low average age for seeking treatment.

I have gone on at some length about why alcoholism is considered to be a disease. Put simply, it is defined as a disease because it is behavior which has all the characteristics and patternings which qualify it for such a definition. I have not even touched on some of the most obvious similarities; e.g., that it has a very well defined symptomatology, that it runs a predictable course, that there are known effective treatments of psychological, medical and social types.

I have dealt with this problem at some length because I am so concerned with the results of the discrepancy between what we say we believe and what we actually believe and how we behave. Until we think about alcoholism as an illness enough to become extremely clear on what we mean by this, we will continue to behave inconsistently. We shall continue to discourage ourselves needlessly by attributing to the nature of the illness what should be attributed only to our own muddled thinking. We shall continue to place unnecessary hurdles in the way of the alcoholic's acceptance of his illness and of his recovery.

It is well to remember that the alcoholic is one of us, and that some of us are in the process of becoming alcoholics. Insofar as our thinking is confused, his thinking is confused. Insofar as we approach the subject of alcoholism in an opinionated way, rather than with an open mind (both with respect to its causes and its treatments), we do not allow him to be treated as any other sick individual who is being helped toward recovery.

Request From Library

We have enjoyed receiving your publication for our library. Will you please send *Inventory* to our school during the 1964-1965 school term?

Lou Wright Roan
Librarian, Sylvan High School
Snow Camp, N. C.

Discussion Guide

I need some material on alcohol which I can present to a Methodist fellowship group. I will appreciate your sending any information which you feel might be helpful in guiding a discussion with them.

Dr. Lee Adams
Goldsboro, N. C.

Helpful Material

I have need for the use of an article in one of the back issues of your publication. It is the May-June, 1962 issue. My copy was loaned out—never to return. I have been an avid reader of *Inventory* since 1954 and find the material therein most helpful in my work. Those of us in "isolated" programs are most envious of the alcoholism work being done in North Carolina.

Eleanore Schafer
Maricopa Council on
Alcoholism
Phoenix, Arizona

Fine Rehabilitation Program

I lived for several years in Asheville and I know something of North Carolina's fine program for the rehabilitation of alcoholics. My church's Commission on Christian Social Concerns is interested in the progress made in your state regarding treatment of alcoholics. Please send me current literature and any printed matter you may have available.

L. L. Trent
Chattanooga, Tenn.

Extra Copies Wanted

It is eight years since I first started receiving your magazine and the number of back copies which I have on file is testimony to both the value and quality of its contents and my high esteem of the same. It is "tops" in my estimation, and a wonderful means for keeping up-to-date after the initial training I received at the Yale Summer School.

I was wondering if it would be possible for me to have at least four more copies of the September-October, 1963 issue of your magazine, *Inventory*. One I would like to put into our church library. One I would like to have for lending out to friends. The other two I would like to make available to the committee of the Community Welfare Planning Council of Greater Winnipeg which is at present making a study of services for juvenile and adult offenders in our city. I feel that it is extremely important that Judge Burnett's article be made available to them.

May I congratulate you on the fine work you are doing through the medium of your magazine and wish you all the best in the future.

Rev. Ian J. Harvey
Pastor, Silver Heights
United Church
Winnipeg, Manitoba

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Progress is hampered more by our reluctance to use all that we do know than it is by lack of knowledge.

WHAT WE DO KNOW ABOUT ALCOHOLISM

BY HERMAN E. KRIMMEL

DIRECTOR
CLEVELAND CENTER ON ALCOHOLISM
CLEVELAND, OHIO

THE battle against alcoholism is weakened by our preoccupation with ignorance. On the platform and the printed page we continuously deplore our lack of knowledge about the causes of alcoholism, about the components of the so-called alcoholic personality, and about many other facets of this complex illness.

A change of emphasis is long overdue. It is true that there is much that we do not know and research is needed to illuminate the areas of darkness. However, it is at least equally true that we do know a great deal about alcoholism and progress might be sharply accelerated if we make the most effective use of the knowledge we already have.

The inventory of that knowledge is impressive. One of the most important things we know, for example, is to recognize alcoholics. Unfortunately, we seem to be more dedicated to looking for definitions than we are to looking for alcoholics. In the meanwhile, we forget that we

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have a satisfactory working definition which says that a person is an alcoholic if drinking continuously damages a vital area of his or her life.

It is as simple as that. Mr. Jones may be a model husband and father when sober but if he horsewhips his wife and throws crockery at the children when he drinks he is an alcoholic. Mr. Smith may be the best engineer in the plant but if weekend binges keep him from work three out of four Mondays, he is an alcoholic because drinking impairs his vocational performance. If Mrs. Johnson's afternoon imbibing repeatedly embarrasses her husband and children she is an alcoholic.

All three of these eminently respectable middleclass people may indignantly deny their alcoholism but that does not alter the facts. They probably know that something is wrong and they need help which they are reluctant to seek because of the stigma still associated with the label of alcoholic. We know, however, that what the victim *calls himself* is not nearly as important as *his recognition* that drinking is creating problems in his life which can be solved only through sobriety.

The semanticist may someday create a definition of an alcoholic that is precise and acceptable to all while education may erase the stigma as it is doing with tuberculosis and mental illness. But until that day arrives, we employ the knowledge we have to identify and help those people whose functioning is destroyed or endangered by the consumption of alcoholic beverages.

We not only know how to recognize alcoholics regardless of what they call themselves but we also know how to help many of them. Moreover, we have learned that we do not have to wait indefinitely for

"Tell Harry he can cut the lau

all alcoholics to want help. Frequently it is possible to intervene, or to help families or employers to intervene, in a way that will compel alcoholics to seek treatment. Motivation is not necessarily less effective because it is imposed externally.

Dr. Harry Emerson Fosdick told of a day in his boyhood when his father paused at the door and said to his wife: "Tell Harry he can cut the lawn today if he wants to." Then the elder Fosdick walked a few yards down the street toward the bus stop before he turned back and called: "And tell Harry he had better want to."

The same principle can be effectively applied to alcoholics. An employer, a probation officer, a wife can say to an alcoholic: "I know where you can get help if you want to—and you had better want to." This can be a constructive aproach because it gives a sick person an opportunity to find out what can be done for him by compulsory exposure to help.

A man came to the Cleveland Center on Alcoholism, for example, because his employer told him that the choice was an appointment at the clinic or dismissal from the job. This was not entirely altruistic because the patient was a highly skilled worker with many years of experience and represented a considerable investment. During the initial interview his denial mechanisms were in excellent working order. Despite several arrests for being drunk and disorderly, despite absenteeism and an impending divorce suit because of violence inflicted on his family while intoxicated, he declared in-

dignantly that he was not an alcoholic and could control his drinking any time he wanted to. If he had been left on his own, he probably would have refused to return for a second interview. With his job at stake, however, he did return. During the fifth interview, he suddenly admitted that he needed help and requested more frequent appointments. Since that time his progress has been reflected at home and at work. Compulsion kept this man in treatment long enough to give the therapist a chance to reach him.

Obviously, this kind of pressure is not necessary for all alcoholics and it does not work for some but each day we are improving our skill in its selective use and we know that sometimes it can be effective.

All these things are important and encouraging but most important is the indisputable fact that we know a lot about the treatment of alcoholics.

We know, for example, that the first indispensible step in treatment is that the alcoholic must stop drinking and all the problems associated with the drinking may have to wait until that step is taken. How he stops is relatively unimportant as long as the means used are consistent with physical and mental health. He may use the support of a therapist or of a fellowship such as Alcoholics Anonymous. He may use medication in acute phases or he may require temporary hospitalization under medical supervision to survive withdrawal symptoms. But we do know that he cannot solve other problems unless he first gives up alcohol so that he can face them realistically.

We know that most alcoholics will resist this first step with an ingenious assortment of ruses because most of them are talented practitioners of the con game. This is frequently their defense against reality. We should know it means that the alcoholic may fool the therapist but the therapist can never fool the alcoholic. This is emphasized by the fact that some alcoholics even manage to hoodwink their sponsors in Alcoholics Anonymous even though the latter have been through the mill. The non-alcoholic therapist, then, must be even more wary to prevent that patient from using fraud to avoid the critical day of separation from alcohol.

If we know that the alcoholic must stop drinking, we also know he must establish a commitment to sobriety. This will happen only when he is convinced that a life without alcohol will be more rewarding than one of continuous or periodic inebriation. Unfortunately, drinking can provide some satisfaction for alcoholics—even for those who have been rendered penniless and deathly ill from alcohol on repeated occasions.

The alcoholic may find replacement satisfactions in a new job, in rediscovery of the joys of family life, in study of Restoration drama or in collecting match covers. He may become "addicted" to something like chess or detective stories. We know that what he does makes little difference so long as the replacement is healthy for him and is not destructive to others.

We know alcoholics can recover and there is no single method that is more helpful than others. Many alcoholics can use the fellowship of Alcoholics Anonymous. Some can-

not. Some can use psychiatric treatment but this is not the only approach to individual therapy nor is it always indicated. Some need medical care while others can use the spiritual resources of the church. Some respond best to the eclectic methods of social agencies. Many alcoholics can best use a combination of aids.

We know that many kinds of professional practitioners can help alcoholics to recover because the treatment does not always require specialized t r a i n i n g. Experience will sharpen the techniques of any competent therapist regardless of his background. Furthermore, we know that one does not have to be an alcoholic to help an alcoholic.

We know that the failure of one or more types of therapy with an alcoholic does not preclude effective help by some other approach. The reasons given by the alcoholic for past failures may not seem realistic to us but, after all, escape from reality may have been a major reason for his drinking. He didn't like his AA sponsor so he attributed one man's imperfections to all members. He may condemn the detached attitude of the psychiatrist, the brusqueness of his physician, the insensitivity of his pastor. Perhaps all the accusations are unjust and he has used them as excuses to continue drinking and to postpone the ordeal of sobriety. But we know that these apparent failures may have provided the foundation on which to build successful treatment. We also know that any of us—individuals, clinics, fellowships—can be anywhere in this progression and we do not have to feel guilty about being one of the "failures" if we have done all within our power to help.

We know it is not always essential to find the cause of alcoholism to effect r e c o v e r y. The symptomatic treatment of stopping the drinking frequently is sufficient to enable the alcoholic to mobilize his dormant resources and to establish a satisfactory life. We know that when pathological drinking stops—especially in the family situation—the environment is automatically changed and the relationships between the people in it are altered. This may be enough. However, we also know that in some cases it is not enough and alcoholics and their families may need additional help with the difficult process of learning to live. Experience should increase our ability to recognize individual requirements.

Finally, we know that we must never surrender to sterotypes. We are working with men and women who share the common problem of drinking excessively but in all other respects they are individuals with individual differences like the rest of us. The same applies to their families. We know enough, for example, to avoid the indiscriminate labeling of the wives of alcoholics as frustrated mothers or hopeless masochists. And we know enough to be skeptical about the generalization that all or even most wives unconsciously want their husbands to continue drinking because of twisted needs of their own.

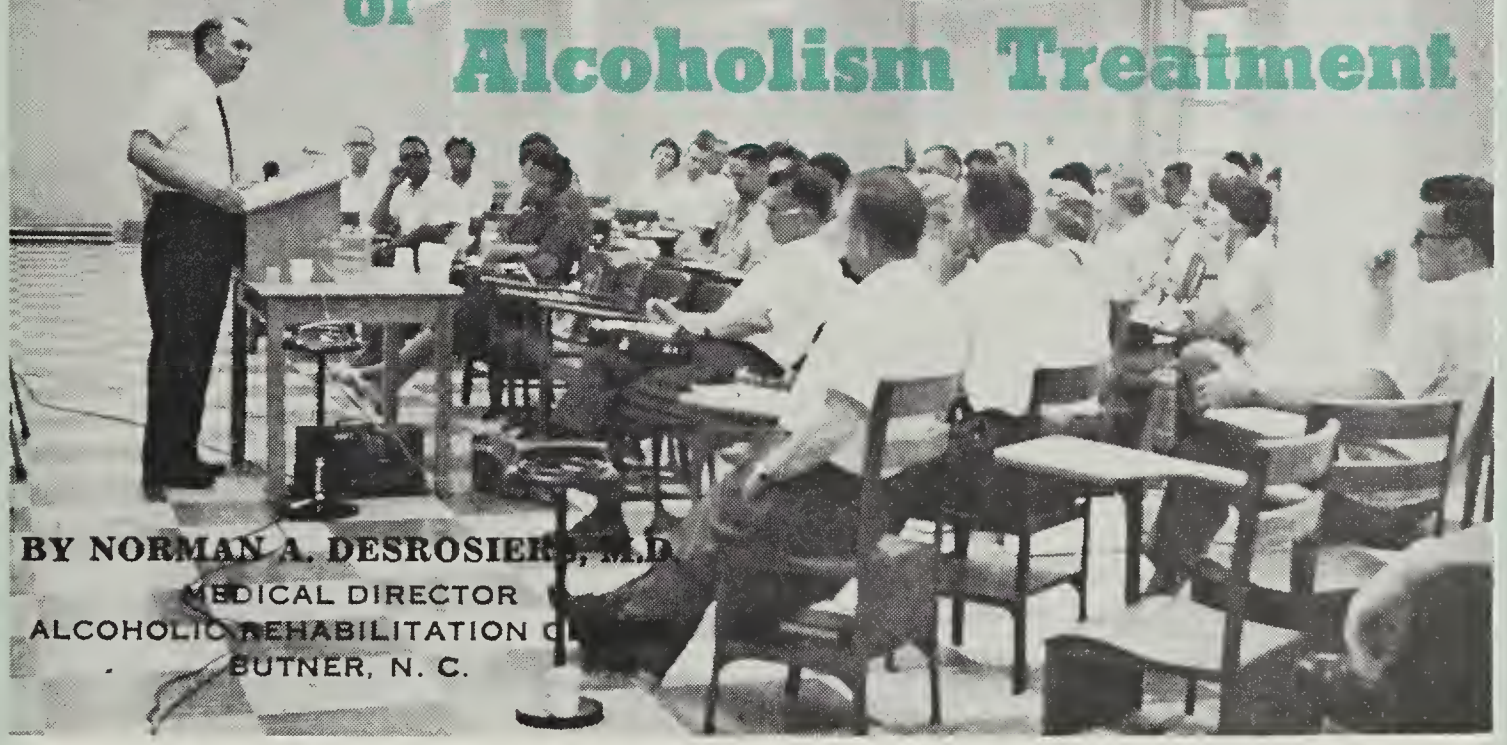
All these things we know about alcoholics and alcoholism and, possibly, much more. It adds up to a considerable body of knowledge. Certainly, there is much we do not know in such areas as causation and prevention so it is essential to encourage and support investigation. We should always remember, however, that progress is not hampered by lack of knowledge nearly as much as it is hampered by our too frequent reluctance to use all we do know.

Early diagnosis—early treatment and a continuum of care and treatment are essential principles in the successful rehabilitation of alcoholics.

This article is based on a lecture given by the author (below) at the 1964 Summer School of Alcohol Studies, University of North Carolina, Chapel Hill. It was also presented before the 15th Conference on Alcoholism of the Boston Committee on Alcoholism in Boston, Massachusetts, May 6.

IN NORTH CAROLINA

The Philosophy and Practice of Alcoholism Treatment



BY NORMAN A. DESROSIERS, M.D.
MEDICAL DIRECTOR
ALCOHOLIC REHABILITATION CE
BUTNER, N. C.

ONE basic tenet of good medical practice is that the *earliest possible correct diagnosis* is highly desirable because of the well-based assumption that the earlier one can institute treatment, the better will be the result for the patient.

If, for example, the tuberculosis patient by neglect or fear or denial postpones and postpones getting medical help, he may well find himself a subject for radical surgery of lung removal for a cure rather than the simpler expedients of bed rest and chemotherapy. The earlier diagnosis and treatment will leave him a lot more operating lung tissue and physical reserve.

The same principle holds true for the chronic, deteriorative process of alcoholism. The earliest possible correct diagnosis of this condition and the institution of appropriate therapy must be effected if we are ever to expect to bring this problem under control.

The implementation of this concept, however, raises serious problems, such as just when is the time to insist on treatment in the development of this disease and just what is the appropriate treatment at this given stage. We have only to recall to mind how vehement the protests of even the "well-along-the-road"

problem drinker will be when he is encouraged to seek treatment to immediately realize the possibility of great resistance developing to this early detection, early treatment concept.

The spouse will aid and abet him or her in his well-known denial at this earlier stage. Those of us in the field know only too well how long the wife of an alcoholic, for instance, will protect him from any real intervention into his abnormal behavior.

Tremendous resistance from a great percentage of the American population may be anticipated if the idea is pushed at all. The complex disease process included in the term, alcoholic, may well be accepted as such by professionally-trained persons, but it is by no means totally accepted by the average layman. Despite all the ideas about alcoholism being accepted as a disease, there is still considerable onus surrounding the calling or naming a person so afflicted an alcoholic.

The early detection, early treatment principle obviously runs into conflict with the idea that an alcoholic must "hit bottom" before he can be helped. In point of fact, many an alcoholic may not hit bottom and seek help, but is in desperate need of help just the same. This observer in too many instances has seen the alcoholic who never "hit bottom" come into the mental hospital as a committed patient for essentially permanent residence under the diagnosis of chronic brain syndrome, not alcoholism. The very idea of "hitting bottom" runs counter to all legitimate medical therapy and makes the task of rehabilitation well nigh impossible in many instances.

When I stress the implementation of the early diagnosis, early treatment idea, I am appealing to a well-established medical principle of preventive medicine and calling for a much broader working definition of alcoholism which will include the early pathological drinker as well as the down-the-roader. I am insisting that noninterference to the point of physical and mental deterioration as represented in the "hitting bottom" idea is a gross distortion and detriment to active concern for the treatment of alcoholics. Unless this idea of prevention by early recognition and treatment can be gotten across to physicians, ministers, social workers, public health nurses, lawyers, judges, employers, families et al, we cannot hope to make a dent in this problem.

Although I feel that the so-called "voluntary" principle is the best treatment approach to date, I am highly skeptical that there is any such entity as a pure culture voluntary patient. Voluntarism is such a highly conditional concept in the motivation for treatment that it can not be depended upon at all to bring early and developing alcoholics into treatment. An understanding of the alcoholic's long and successful use of denial ought to make us aware of this fact.

The greatest majority of patients who come to our voluntary treatment center are "voluntary" only because of a last ditch stand of a distraught spouse, parent, judge or employer on a "you-go-or-else" basis. The staff all heartily endorse the principle of voluntarism, realizing all along that it is usually a "participating decision" on the patient's part. We never ask our patients whether they are alcoholics. We simply proceed on the assumption that they are.

A second major point to consider in the philosophy of treatment of the alcoholic is the necessity of ef-

fecting *a continuum of care and treatment.* All of us in the field are in hearty agreement with Dr. Tiebout's oft-quoted statement that there are two major problems in the treatment of alcoholics; namely, *getting them to come and keeping them coming.*

I use the term *care and treatment* because you are not going to *get* to do any treating of an alcoholic if he doesn't get some caring from you. Herein is where the impersonal, coldly scientific approach of medicine, lacking the human care angle, falls flat on its face when it attempts to relate to the alcoholic. Effecting a continuum of care and treatment, difficult as it may be, is one of the keys to the rehabilitation of the alcoholic.

Basic Tenet

A therapist-patient relationship with an alcoholic may well be a lifelong relationship. A professional worker who is not prepared to accept this basic tenet had better not enter the field. Any other attitude in working with alcoholics simply will not work.

I hasten to add that such a statement does not intend to imply that the relationship with any given alcoholic will be *continuous* through time, but a continual type of contact may well be expected. This should not appear so strange after considering a close analogy in medical practice. The general practitioner who accepts a patient for treatment of a chronic lung condition, for example, will treat the acute exacerbations of the chronic condition, such as pneumonias, as they flare up and, as his personal physician, follow him until the day he expires. He will not get angry with the patient when he gets pneumonia and his condition worsens; he will hospitalize him and ply every resource of his profession to return him to as close to his optimum health as possible.

So likewise it must be in the therapeutic relationship one establishes with the sick alcoholic. His condition is much more complex, involving the total aspects of man — mind, body and soul — but the therapeutic continuum of care principle is still the same and still absolutely essential to treatment. The therapist who expects to "treat" the alcoholic once and for all and see him no more is doomed to failure because the alcoholic can sense his vision of his role.

Treating alcoholics is not like cutting out an appendix. It is like treating chronic lung disease. Alcoholism is chronic. It has residual impairment to adaptive functions. It has exacerbations. It has remissions. The therapist must be prepared to deal with alcoholism as a chronic illness if he hopes to have any measure of success. He must be prepared to accept apparent failures with grace as part and parcel of the work.

We have been concerned with establishing two basic points in the approach to the treatment of alcoholism: namely, the absolute necessity of early diagnosis-early treatment and the idea that this specific disease process is a chronic condition that requires a continuum of treatment which any would-be therapist or therapeutic group must be prepared to accept.

Let us now consider getting the alcoholic to come for treatment, treating him, and following him along by maintaining a continual relationship with him or, in different terms, *early detection and referral for treatment, treatment in all its aspects, and aftercare.*

Our philosophy with respect to getting the alcoholic and even the developing alcoholic to come for treat-

ment has already been alluded to, namely, of attempting to detect excessive or pathological drinking at its earliest stage and putting the pressure on to get him into a treatment situation as soon as possible.

Again, I would stress the fact that it is sheer folly to sit around waiting for the alcoholic, and especially the developing pathologic drinker, to appear for help. He simply does not appear this way because of his well-known denial mechanism—that self-protecting bit of psychic perjury the developing alcoholic practices for so many years. One of the reasons that he is able to get away with it for so long is that we, by accepting his denial that he is losing control, are just as guilty of using denial as he is. To have perpetually bought the pathological drinker's denial of his state is to have bought a delusion as well as to have excused ourselves as physicians, employers, ministers, states, etc. from making any more than a token attempt to develop treatment programs for him.

The major point to be emphasized here is that a laissez-faire attitude on the part of society (and we are the concerned element in that society) toward pathologic drinking will get us no further than our present stalemate in the battle against this disease. I believe that our present stalemate, and probable regression, with respect to the control and treatment of alcoholics is *not* because we don't know enough about the entity, its causations and how to treat it. The real problem lies in our morally super-permissive attitude toward excessive drinking and our cultural laissez-faire attitude toward this serious problem.

In our own state, hopefully, the development of a much more aggressive attitude—and I might add a more realistic attitude—is being cul-

It is sheer folly to sit aroun

tivated and adopted. Through the efforts of our Education Division, under Dr. Norbert Kelly, as well as the treatment staff at the Center, an almost continuous stumping of the state is being effected in an effort to educate our people in the realities of this business.

These efforts have produced some early tangible results. The most important to date is the revision of the mental hospital code in 1963 which finally ended discriminatory legislation against the alcoholic and recognized him both as being as sick as any other mental patient, legally, and as worthy of inpatient treatment for the same length of time. The alcoholic can be treated up to six months if it is indicated in terms of organic symptoms or serious psychopathology.

More facilities in the nature of the voluntary treatment center at Butner are also being planned. Enough bed space is planned, for example, to accommodate roughly one-seventh of the total known alcoholic population in any one year which, hopefully, will fill the requirement of that hard core of alcoholics who need hospitalization—whether voluntary or judicial—in order to interrupt the vicious cycle of their drinking. This is evidence that the state, at least, is finally taking this public health problem extraordinary seriously.

The median age of the alcoholic being admitted to the Center has dropped from 45 to 40. More women are coming out of hiding and seeking help, so many, in fact, that at one time this year there were 12 women and 24 men—a ratio of two to one. We *are* beginning to treat the symptoms of pathologic drinking earlier

and we predict in years to come that our results, if we can ever measure them, will be better.

Such, then, are a few of the tangible results of our more aggressive attitude toward early diagnosis-early treatment. Patients are applying for treatment at the rate of 125 to 150 per cent of our available bed space on a *voluntary* basis. It does work!

Any discussion of treatment and the method of effecting it must begin with the handling of the acute alcoholic, his withdrawal, and his convalescence. Because they will not admit them, it would appear that many local community hospitals, private or otherwise, and a large proportion of the physicians therein, either do not believe that the acute alcoholic is a medically sick person, or know it and refuse to do anything about it.

If they do not believe that he is sick, often constituting a medical emergency, they must be taught that he is. I cannot emphasize this point too much for two reasons: (1) The size in numbers of this particular medical condition is so great that the local community hospitals and physicians must help take care of their problems; and (2) I am firmly convinced that a considerable amount of physical deterioration could be prevented if adequate medical therapy were promptly administered.

You see, I am one of those unpopular guys who believes, like Courville of California, that ethanol poisoning is the most common form of poisoning of the central nervous system and that the chronic deterioration of personality and social adaptive function in the alcoholic is one of the outward clinical manifestations of the gradual bit by bit deterioration of neural tissue. Skeptics and all should read very closely Courville's monograph entitled "The Effects of Alcohol on the Nervous System of Man." It contains some terribly convincing microscopic sections from the autopsy table from neural tissue all over the body. Where the perpetuated delusion that ethanol is a non-toxic aliphatic alcohol with entirely and totally reversible effects on neural tissue in man comes from, I cannot yet fathom. Any agent which acts by inhibiting the most sensitive needs for oxygen in neuronal tissue cannot be considered benign or non-toxic, especially when repeatedly self-administered in an uncontrolled manner.

In short, one cannot deprive a nerve cell of even small amounts of oxygen for days on end, deprive it of another of its basic nutrients—glucose—by depleting the liver of glycogen, and dehydrate that cell as well and in any reasonable manner expect it to survive totally intact and functional or even to survive at all. The total bite on the mass of millions of nerve cells as a result of any given binge may appear small, but it is a bite. Were our diagnostic tools accurate enough, perhaps it could be measured; at present, in most instances it cannot be until the summated bites make themselves known in relatively gross clinical form.

We insist that the acute alcoholic receive as immediate and as definitive medical care as can be afforded him at the community level in order to minimize the inevitable neurologic damage that occurs resultant from excessive alcohol intake, and the other deficiencies concurrent with

this state. There is the medical business of preventing delirium tremens and the ever present threat of convulsions, of dehydration and fluid balance, of restoring positive carbohydrate and nitrogen balance; there is the proneness and possibility of infection, and there is the necessity of a period of convalescence—always apparently overlooked and always the point where the idea of a continuum of treatment is broken.

We have pushed this idea of local community responsibility for the medical treatment of the acute alcoholic in our voluntary treatment center by refusing to admit inebriated individuals. We tell the physician who calls us our policy and recommend that he carry out the withdrawal procedure in his local hospital. Then we tell him that we will be glad to take the patient from there when he is sufficiently along in his convalescence to be able at least to navigate. We also warn him that his patient's desire for further help may well take quite a different twist when he begins to feel better physically, and to please call us back if he can persuade him to come for a month when he is fully sober. You know what happens. Half of those second calls are never made. The half that do elect to come (usually under much pressure) appear better motivated, at least, and usually remain the full four weeks.

When these patients do come, however, even after seven to ten days in the hospital, they are a long way from their best physical health. They need continued convalescent care, rest, and medical attention. They have got to stop being sick on their stomachs, anorexic, and learn to sleep again, eat again and begin to feel thoroughly human again before one can entertain any ideas of psychological work with them.

I won't go into the details of the dietary and medical care that goes on during this period. What is important to realize is that there *is* a period of *convalescence* after any given binge—longer or shorter depending upon the duration of the binge—and that this second stage of treatment is just as important medically as the acute stage, and that any real psychologic type approach is more likely falling on unresponsive ears.

It is not true that because alcohol is out of a person that he is a fully functioning individual. Seldon Bacon's "half-man" concept is appropriate here. In the vernacular as our staff physician puts it, "They've got cobwebs on their brains" for longer than we realize.

Convalescent Stage

It is precisely at this stage of convalescence, as was mentioned earlier, that the opportunity with respect to getting the alcoholic to accept further treatment is usually lost. He feels better, his denial mechanisms are working again, and we tend to buy them by letting him sign out of the hospital against advice or blandly accept his promise to show up at the outpatient clinic or AA meeting —which he rarely does. And we blame him for not coming! It is not he who is at fault; he is still sick. What the alcoholic desperately fears is that anyone should wish to "help him," that is, begin to look into his life with him, into the nature and quality of his interpersonal relationships and his intrapsychic life—and of course, he runs and *we* fail *him*.

Those in the field must come to realize that in the acute and convalescent phases of this illness the cognitive functions are the ones that are seriously impaired — first, namely, recent memory and the closely associated learning process.

The *acute* alcoholic *is* the full-blown Korsakoff psychosis in temporary chemically induced form—and who would attempt rehabilitative psychotherapy on a Korsakoff? Even the convalescent period is a time for medical and the simplest of psychological supportive therapy. Only gradually can one move into a more intensive psychological approach. Failure to recognize this, I am afraid, results in much wasted, though perhaps necessarily so, time and effort on the part of outpatient staffs in particular.

I am not suggesting that those of us in state-supported or voluntary organizations push every new contact into an inpatient treatment setup. That is not possible. But it is important to realize that when a person begins to repeatedly go on binges, gets into trouble with the family, the law or his employer—not twenty times, mind you, but the first or second time—then he may well need to have help for several weeks to a month of inpatient treatment to keep him away from alcohol, to convalesce him, and to get him a solid beginning in rehabilitation.

Those first days are hard days for him and he needs the medical support, the emotional support, the acceptance of his condition, and the help of fellow sufferers—not fleetingly and periodically, but continuously. AA knows and practices this well. The once or twice a week chat with him is not enough at first. It may be later on in the continuum, but not in the early stages of treatment.

We practice these principles in our four-week inpatient treatment program. Its main thrust is group psychotherapy which moves from the structured, supportive variety in the first two weeks toward unstructured consideration of the intra-psychic life in terms of feelings.

With beginning group psychotherapy, we begin to prepare the patient for what we would like to see him do when he returns to his home environment. He is assigned to a therapist for group and individual sessions who becomes responsible for him—under medical supervision — for the entire four weeks. In this manner, the idea of a continuum of treatment is carried out even while the patient is at the Center. His therapist is also responsible for seeing that a positive follow-up program is arranged before the patient leaves.

We maintain a very close relationship with such local agencies as mental health clinics, family service societies, aftercare clinics, and alcoholism information centers where therapy is done because it is from these centers that the patient comes and to which he returns. It is here, also, that the family of the alcoholic is worked with, the necessity for which should be stressed. All of us know how much emotional pathology there often is in the spouse of the alcoholic which must be treated if we hope to effect any significant amelioration of a given patient's condition. Reaching both the spouse and the alcoholic has the beneficial effect of helping to change the charged emotional environment in which many a helpless child is fostered as well.

In summary, the philosophy and practice of alcoholism treatment as it is presently effected in North Carolina is based on the sound medical principles of *early diagnosis-early treatment* and *a continuum of care and treatment,* with the continuum beginning in the acute stage and continuing through convalescence uninterrupted to inpatient treatment (when indicated) and/or aftercare treatment which offers a continual-type contact.

ALCOHOLISM has been presented as a many-sided and complex community problem, and I am sure that you agree that it is a weighty and serious condition and that work on a community health problem which is as chronic, complex and many-sided as alcoholism, requires fortitude and determination.

First, I'd like to share with you some of our experience with, and feelings about, early detection or early case finding with emphasis on the fact that the earlier treatment is initiated, the better the results, a principle that is as true for alcoholism as it is for other disease processes.

There are many ways of illustrating this.

The first place the problems of misuse of alcohol are likely to show up is within the home in the family situation of the individual. This means that the husband, the wife, and other household members are usually the first to become aware that an alcohol problem is developing. Please keep in mind that I said *other household members,* because I'd like to come back to this point.

Probably the second place that alcohol problems begin to show up is at work in the job situation. Nervousness, decrease in efficiency, inability and a general hung-over appearance could be the results of excessive use of alcohol. When these signs are accompanied by a characteristic absenteeism, (an absenteeism pattern frequently described as "Monday morning flu"), the chances are more than good that the employee *does* have a drinking problem.

● *The school system can be a fruitful case finding resource.*

BY MARSHALL ABEE

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COMMUNITY RESPONSIBILITY for CASE FINDING and PREPARATION for THERAPY

Later manifestations that are quite evident include trouble with the law, such as arrest for drunkenness, disorderly conduct, drunk driving, etc.

These are some of the obvious ways of early detection or, at least, relatively early detection.

Now let me return to the other members of the household. This is a potentially fruitful source for early case finding that has been overlooked or not faced, and has had very little emphasis placed on it. In fact, in my reading, I don't think I have ever run across any writer who has placed any emphasis or importance upon the school system as a case finding resource. We have found it quite important. Children know family problems whether we admit it or recognize it or not. They know about them and they worry about them and they talk about them.

Recently a fourteen-year-old girl came to a guidance counselor's office and, after some preliminary discussion to assure herself of the confidentiality of this particular person, she told the story of her alcoholic mother and in a tone of desperation she asked, "Will you help me get my mother committed to a hospital?" Can't you imagine the anguish that this fourteen-year-old youngster went through to come to this decision? And the difficulty it must have been for her to talk about this to a person who was a relative stranger to her?

The public health nurse, the welfare department, the guidance counselor and our alcoholism program are now involved in this case which is showing some encouraging improvement. The mother is under treatment and the girl is getting help through counseling in hopefully developing some understanding of the problem.

About six months ago, one of our school social workers was called to a school by a sixth grade teacher. When the social worker arrived, she was met not only by the sixth grade teacher but also by the first grade teacher. It happened that each of the teachers had a child from the same family in her class. Both of the children as described by each of the teachers had demonstrated frequent emotional upsets and had come to school frequently with the same story of drunkenness at home. After home visits were made to verify the suspected conditions, the school social worker conferred with the alcoholism program and some other agencies. An appointment was made with the alcoholism program's psychiatric social worker for the mother and the father, and the school social worker saw to it that the parents kept this appointment.

Unfortunately, that was the only appointment the father kept. Within ten days, he was a "guest" of the state and a week or so after that the children became wards of the Domestic Relations Court and the mother was placed on a suspended sentence for neglecting the children.

Incidentally, the mother is now coming regularly to the clinic. Again, we are not sure what the results will be in this particular case, but it seems the motivation is very keen on the part of the mother because, of course, she wants to regain custody of the children.

These are only two illustrations of thousands of similar cases occurring throughout our state that could be found and brought to treatment by school personnel. There are many more that could be given with perhaps more dramatic and successful results.

I can't help but wonder if we aren't missing a great case finding opportunity in the schools, particularly in the primary grades. I have

one child who has just gone through first, for instance, and another who has just gone through third. Both of them have delighted over a brief period of time which occurs every Monday morning in the life of the primary grade child—and that is the Monday morning "show and tell" period. Now those of you who have any experience in teaching know that children *show and tell* a great deal. The teacher in the classroom has a real opportunity to detect early signs, to make referrals to the social worker, welfare department or to the public health nurse who has immediate access to the home and could do some discrete visiting and leaving of information.

For a long time it was believed that nothing could be done for the alcoholic until he was ready to accept help, but within the last few years this statement has been shown to be untrue. It *is* possible to intervene forcefully in the alcoholism process utilizing one or another technique of compulsion.

The employer can lay the job on the line, "Get help or lose your job." The wife (or husband, as the case may be) can put the marriage at stake if she really means it when she says, "Get help or get lost." Several courts in our state are nolprossing cases on the condition that the defendant seek and get help.

The experience of a number of clinics and treatment centers with these cases of compulsory treatment indicates that treatment results among those under court order or stress or force are just as good as those who voluntarily apply for treatment. The most important thing we must keep in mind is this: The earlier that the alcoholism problem is recognized and identified and the earlier that intervention is started, the better are the treatment results. This has been proven time and time again in our own program.

We seem to have greater success with patients who have been referred by employers who have placed their jobs at stake. Unfortunately, we don't have enough employers making referrals to us, but we have observed that our better results in treatment come from employees of companies with whom we have the closest relationship.

The Alcoholism Program of Forsyth County was organized in 1952. At that time, one of the statutes governing the state's Alcohol Beverage Control (ABC) System specified that a percentage of ABC profits on the local level could be used for educational purposes, but did not specify treatment. Therefore, the people who planned and studied and set up our particular program divorced it from the ABC system so that it could begin with treatment as well as education.

The "founding fathers" put us under county administration supported from the general funds of both the city and the county, with 75 per cent coming from the city and 25 per cent from the county. ABC profits, incidentally, are divided in the same ratio to the general funds, but they go into one pocket. We dip into that same pocket and get them back out, but they are "cleaned," so to speak, as they go in.

The program was started with a staff consisting of a clinical director, a psychiatric social worker, and a secretary. We now have a full-time

as been shown to be untrue.

executive director, psychiatric social worker and secretary; three part-time psychiatrists and a psychiatric social worker; and an internist and psychologist on a fee basis.

The psychiatrists conduct both one-to-one and group therapy. There are two one-to-one clinics, one held in the daytime and the other in the evening, and one evening group therapy clinic.

Over the years, but particularly in recent years, we have seen the need for night clinics grow, mainly due to the increasing number of people being referred to us by industry. Sometimes, the employer will allow time off with pay to come to the clinic, but most of the time the employee actually loses money by having to take time off to come. We feel that our night clinics will be able to serve quite a few persons who are not able to avail themselves of the daytime program.

Our internist, who is in general practice, sees and examines all the patients that we feel need to be seen. He particularly sees those patients who are seeking hospitalization in our local facility.

We have operated a six-bed hospital facility known as the Nursing Care Center for some twelve years. The patients stay on an average of three to four days and the facility has functioned as more of a drying out center, which as you know is a much-needed local facility, than anything else. However, our social worker does visit each patient while he is in the hospital to explain the various community facilities—our clinic and Alcoholics Anonymous, in particular—of which he can avail himself. An appointment is made for each patient with our clinic irregardless of any notion the social worker may have regarding whether or not it will be kept, and the patient is given a card to remind him of it.

The alcoholism program underwrites the cost of hospitalization, that is, pays the Nursing Care Center, and then bills the patient. This ties the patient to our program, and you'd be surprised at the percentage of repayment we get—which is increasingly getting better. Three years ago, it was about 46 per cent; year before last, about 48 per cent; and about 60 per cent this year.

The latter may be accounted for by the fact that we have become somewhat more acutely aware of the need for the patient to accept responsibility for his own hospitalization and, during the past year, have therefore put forth a little more effort in getting him to accept this responsibility.

Our patients frequently ask, "How much is this going to cost?" and add, "I'd like to pay something"—which indicates to us that patients perhaps do have a feeling of receiving something of value, or more value, if they have to pay for it. However, even though we have discussed the value of placing a sliding scale fee on our psychiatric and counseling services, we have been unable to develop anything on this basis up to now and hospitalization is the only service we offer which has a fee attached to it.

Our services include, in addition to those already discussed, social work counseling with the family as well as the alcoholic, consultation with other agencies, industry and individuals, both professional and lay, and assistance in gaining admission to the Alcoholic Rehabilitation Center at Butner, a state mental hospital, or to our own hospital facilities.

Since our educational program is

not too dissimilar from alcoholism education programs in other communities, I will not discuss it in detail but merely summarize and present a few of its more encouraging results.

One of the most encouraging recent developments is the interest shown lately by our hospitals after twelve years of disinterest in educational programming. Last year, for instance, we were invited into the hospital setting on three different occasions—to a school for nurses, for a hospital staff meeting, and to the School of Pastoral Care at North Carolina Baptist Hospital.

This was our first invitation to participate in the pastoral care school, and we have been assured of time to present an educational program before all future classes that go through the school. The offer includes a two hour session one day to be followed by a two to three hour session the following day.

We are also proud of our work with the Winston-Salem Police Academy which is noted as one of the finest police training centers in the state. Three years ago we were requested to present a two hour program to a class of twenty young recruit officers. The second year they gave us four hours—this year, six.

I would like to conclude with a quote from a recent textbook, *Alcohol Education for Classroom and Community,* published by McGraw-Hill and edited by Raymond G. McCarthy. The quote is from the chapter "Alcoholism: A Public Health Problem," by John R. Philp, M.D.

". . . Education designed to increase the knowledge and skills of the many professional people who, in the course of their daily lives, come into contact with the alcoholic will do much to increase the total resources for treatment and rehabilitation in each community. The immediate, realizable goals of community programs dealing with alcoholism are:

"An informed public: Citizens who recognize that some people cannot drink in moderation and that these people should not be blamed for the condition that made them alcoholics.

"An enlightened law enforcement system: Police officers who have some knowledge of alcoholism and who consider helping alcoholics, as well as protecting the right of others, a part of their job.

"Courts and laws which recognize that help for the alcoholic is far more effective than punishment.

"Physicians who are willing and able to treat alcoholism and who will join others in the community in offering help for the alcoholic.

"General hospitals whose beds are as available to acutely intoxicated alcoholics as they are to other acute medical cases, and nursing staffs who recognize that there is more to alcoholism than intoxication.

"Clergymen who are aware of the spiritual problems faced by alcoholics and their families and who are prepared to use their counseling skills to help rather than to condemn.

"Social agencies which offer their help to families where social problems have been intensified or created by alcoholism and which use their skills also to help the individual alcoholic.

"Health agencies that feel as much responsibility toward alcoholism as they do toward any other public health problem.

"Employers who recognize the early symptoms of alcoholism in employees and who protect their investment in these people by getting help for them before their jobs are jeopardized.

"Schools that teach objectively."

Pastoral Counseling —the FOCUS of COMMUNITY CONCERN

BY REV. JOSEPH L. KELLERMANN

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Published by permission of the author (right), this article was originally given as a talk at the 15th Conference on Alcoholism of the Boston Committee on Alcoholism, Boston, Mass., May 6.

The minister's primary role is to take the lead in creating a climate in which the problems of alcoholism can be solved by the community.

FROM my vantage point of full-time work in the roles of minister and counselor in the field of alcoholism I see two primary areas of responsibility if a minister is to be successful in counseling in the field of alcoholism. First, he must learn something of the basic nature of the illness of alcoholism and the dynamics of recovery. The harm done by many ministers who try to counsel in this field is unbelievable. Basic knowledge is essential. Secondly, he must constantly attempt to change the attitude of the community.

The role of the church is to create a climate in which the problem may be solved and the minister must take the lead in this or it will not get done. For example, most persons think my primary task is informing alcoholics. It isn't. I interview far more wives of alcoholics than alcoholics—in fact, several times more. My primary task, though, is to inform the community. No matter how successful I am with alcoholics, or in counseling their wives and family members, unless I succeed in educating and informing the community of the nature of this illness and motivate the community to learn more and act upon this knowledge, I have literally failed.

I am reaching some alcoholics and am helping many families of alcoholics, but I am not reaching the top leadership of my own community or my own church. The indifference of the alcoholic to his need for help in recovery is surpassed only by the apathy and indifference of the community which fails miserably to meet the needs of the alcoholic and especially his family.

To put it bluntly, many alcoholics or their family members come to my office or phone for advice and counsel. Few ministers have the courage to walk in and state that they are helpless in dealing with their alcoholic church members. The average minister has greater resistance to admitting he needs help with his alcoholic church members than the

average alcoholic or his family has in admitting the need for outside help. Pride rests more comfortably in the pulpit than in the pew, unfortunately.

The need for basic knowledge and the need to change the community attitude go hand in glove in pastoral counseling. No pastor can act as a shepherd if his flock acts like a pack of ravening wolves. A minister will have little success in counseling a member of his flock if the attitude of other members of the church is that an alcoholic is a no-good bum, a criminal and a scoundrel.

A few years ago a woman who had practiced medicine in our community for years came to discuss her husband's alcoholism the day after he had been fired from a job he had held for 20 years. He was vice-chairman of his church board and the minister lived in the same block. The wife was extremely anxious to conceal the problem from the minister, stating that if he discovered the fact her husband would resign and never attend his church again. This is like saying that if the doctor discovered the patient had diabetes the patient would leave the hospital and never visit the doctor's office again. This doctor could not see the alcoholic as a sick person; this was her husband and she felt a great sense of shame and disgrace for him.

If the pastor is to deal effectively with alcoholics he must change his own attitude and also the attitude of the nonalcoholic members of his congregation. The most striking need for this was revealed to me on one occasion when I went to visit a business executive who turned my visit into pastoral counseling by shutting the door to the outer office and bending my ear for one solid hour about her deceased alcoholic husband. The key statement was this: "Everything my mother and grandmother taught me about being a woman, everything my Sunday School teachers and ministers taught me about being a wife conditioned me to be totally unprepared to cope with my husband when he became an alcoholic." Her sense of guilt in not saving her alcoholic husband from an untimely death due to drinking was the over-riding burden of her life. Her family and her church had conditioned her to fail. The real tragedy is that this conditioning process is still in effect. I must change this preconditioned attitude before I can help any client—alcoholic client, family client, employer client, and sometimes social worker or doctor dealing with the client.

Let us now turn our task to the first factor in counseling—a knowledge of the illness. The late Dr. Jellinek in his book, "The Disease Concept of Alocholism," lists five basic types: A. The situational drinker; B. Type A complicated by organic disturbances; C. The rather constant drinking pattern or non-remittent alcoholic; D. The plateau drinker or constant nipper who never becomes intoxicated but is very dependent on alcohol; E. The person who has a binge with long intervals of sobriety.

As type C is most prevalent in America today and is very progressive in its destruction of the patient and the family, we will consider this type as the one most likely to bring trouble to the largest number of persons. It has four definite stages of development—the loss of the ability to drink temperately, the loss of memory of drinking experiences, the loss of control or the inability to abstain, and the inability to regain sobriety once intoxicated, or, true addiction. The hardest thing for a nonalcoholic to understand is that most alcoholics drink because they

are unable to abstain. It is even harder for the alcoholic to understand and all sorts of defense mechanisms are set up to disprove this fact.

However, there is one basic common denominator in all five types of the illness which appears in social histories as well as in treatment. The alcoholic learns to use alcohol as a medicine and drinking becomes a way of life, a problem-solving mechanism, which despite anything we might think, is to him a source of comfort and a successful way of life. The alcoholic is a person who discovers by chance or experimentation that alcohol, nonspecifically, dissolves all anxieties, reduces all tensions, releases all hostilities and solves all problems—but for the time being only. Getting drunk is not the illness—the illness is the heartache which the patient attempts to relieve by drinking.

The Crux of the Problem

The crux of the problem is that the patient learns that alcohol changes the entire subjective world around him. Alcoholism is sometimes called a religion of transcendence achieved by a simple chemical drug. For the moment the omnipotent desires of the patient become a reality. No matter what problem faces the alcoholic, nor what painful condition arises, experience teaches him that alcohol contains the answer. Any problem is soluble today in alcohol although it recrystalizes tomorrow in a larger lump with sharper edges.

As the disease progresses the entire behavioral pattern changes gradually. The trend is from the simple to the complex, from the mild to the acute. Life for others becomes more distorted but for the alcoholic there is always more alcohol to dissolve the bigger problem.

This cannot occur, however, without the ability to impose this method of problem-solving upon the family, the employer, and, at times, upon the community. It is as if the alcoholic flunks every major emotional test but the family gives him a passing mark because they are embarrassed for the community to know the truth. In this capacity the family becomes the teacher and the student learns that no matter what happens he will not be allowed to fail.

Recovery is also a relearning process for the alcoholic, preceded by a relearning process in the family or with the inability of the family to protect the alcoholic from the failure which A.A. calls "hitting bottom." If the alcoholic is to un-learn or to relearn new methods of coping with the reality of life, others must assist in the progress.

Community attitudes toward alcoholism help to determine what action will be taken by a family toward one of its members. When tuberculosis was called consumption and stigma was involved, the family hid the tubercular patient in a back room and the doctor came secretly to treat the patient. Today the alcoholic is the leper of our modern society, the TB patient of 50 years ago. We must do for the alcoholic what the TB Association has accomplished for the tubercular patient. Alcoholism is increasing more rapidly than our treatment facilities are expanding. The only hope is education, early detection and treatment, and most of all, wherever possible, the prevention of alcoholism. Treating the alcoholic is important but teaching the community how to cope with alcoholism is *more* important.

What we learn about the dynamics of recovery teaches us what we can do in motivating early treatment and possibly preventing the appear-

ance of compulsive drinking or crucial alcoholism. I went around the country for several years asking the question, "Does the alcoholic have a right to drink?" Mr. Ernest Shepherd was the first person who gave me a qualified "yes," which was based on the qualification, "unless we can provide him with a better solution for his problem." Alcohol is a specific drug for anxiety, tension and resentment and the alcoholic—by trial and error—discovers this chemical truth.

Alcoholics Anonymous is one example of the better answer to the problem for many. It is a program of attraction—a better way of life. A. A. is also a community which is more similar to the first century church than any other example in American life today.

It is also possible to find a better answer to the problems of life through psychotherapy or in a treatment center or clinic, yet only 5-10% of alcoholics who need help find their way to Alcoholics Anonymous and treatment facilities would need a tenfold increase to begin to be adequate to meet the needs. Only a small fraction of the people who need help find a better way.

Unless we have the courage to structure a relearning process most alcoholics will die before seeking help. This is the most tragic of all factors in the area of treatment. Alcoholism is a treatable illness and the vast majority of alcoholics could recover and lead relatively average lives if properly motivated. Dr. Gordon Bell states that the alcoholic is locked in the phase of resistance. If we wait until he wants help he may die because most alcoholics are not able to recognize that they need help, or recognizing the need, cannot bring themselves to admit it. The alcoholics of our country are locked

Without a better solution t

into resistance and unless someone has the key or breaks the lock most of them will die before they learn to stop drinking.

The basic question is who has the key and who can break the lock of addiction? In my former parish I saw five persons die from chronic and acute alcoholism despite repeated warnings from doctors that they would die if drinking was not eliminated. Knowing each full well I can make the following statement without reservation: In each case the next of kin or the immediate family cooperated fully in the perpetuation of the disease. The pride, the shame, the sense of disgrace, embarrassment —all these things inhibited the family from correct action. Let's take a look at several of these cases.

One was a very ingenious man, age 45, of a wealthy family which sent his check whether or not he went to the office or did his work. His wife let him sit at home for two or three years and drink himself to death without ever seeking help for herself or trying to force the issue. Family pride cost his life.

A housewife with two high-school-age sons died at 42. Her husband was unwilling to stop drinking and after each return from the hospital there would be short periods of abstinence on her part but none on his. Sooner or later she would join him and a month later would inevitably be back in the hospital.

Ironically, both of these persons died in a hospital which does not yet admit and treat alcoholics. This is one reason both died—the doctor, the hospital, and the family never treated the real illness, only the physiological results of intoxication.

heir problem most alcoholics will die before seeking help.

The third death occurred when the young man was 39. Ten years ago he and his first wife were sponsors of the youth work in my parish church. He refused to accept treatment for alcoholism and his wife divorced him. His parents always fed, clothed and housed him regardless of his condition. In his late thirties he married the widow of an alcoholic who worked and brought home a bottle each day and two on Saturday. A massive liver hemorrhage took his life. Both parents and his second wife aided and abetted his death.

Pride is the most deadly of the mortal sins and for the family of the alcoholic and the patient the price is death. Pride, not drunkenness, is the basic sin involved on the part of the family and the alcoholic.

One of the men in my parish was more fortunate. For nearly 20 years he lived in an alcoholic blackout. Then his mother died. I had urged him to leave home and told his mother it was immoral to continue to support him. With her death the basic handicap of recovery was removed by divine intervention. He came to her grave drunk, sobered up, joined A.A., had one early slip, recovered, married at age 40 and made rapid progress in his professional work.

Another parishioner in his mid-thirties was given a choice by his wife. He could throw away the bottle or throw away his marriage. It was something of a struggle but she held to her choice and he made the final decision for sobriety. With adequate help, especially from A. A., he made a marvelous recovery. Last fall he became president of the men of his church. The first program he arranged was to invite me to speak on the subject of alcoholism.

Last month I visited the Personnel Services Department of Allis-Chalmers and interviewed Henry Mielcarek, head of this department. Their alcoholism rehabilitation program was instituted 20 years ago. By actual count 92% of their problem drinkers offered help on action initiated by the company have been helped and made a recovery. Prior to this time over 90% of their problem drinkers were eventually fired.

Education, known policy, extremely adequate rehabilitation services and the discipline of aggressive action motivate nine out of ten persons who show signs of problem drinking to accept treatment and recover. Over nine out of ten alcoholics can be motivated to accept help and recover if the family and the employer know what to do and follow through with a plan. From a point of view of pragmatic observation, the treatment which an alcoholic receives which motivates him to recover comes not from the doctor, minister or psychiatrist but from the primary persons in his life. Therapeutic treatment is effective only if the family and/or the boss no longer allow the alcoholic to use alcohol as a therapeutic agent. In simple language, motivation occurs when he suffers the consequences of drinking—not the family or the company for which he works. Both must offer help in recovery but not help in escaping the responsibility of life.

Words mean little in dealing with alcoholics unless words are backed up by consistent action. Play acting, threats, promises mean nothing. The alcoholic never hears what his wife

tells him. The only thing he hears and understands is what she does. A change in attitude and a change in approach is a must if we anticipate a change in the drinking pattern. Most wives phone our office asking if we can help their husbands with their drinking problems. We suggest that the wife come to our office and let us help her. If she is able to free herself from shame and guilt and approach the problem from an entirely different point of view we witness miracles of recovery. If she stays in the same old rut the husband will keep his nose in the same old bottle.

The pastor has a responsibility not only to the lost sheep of his flock but to the flock itself or he is a poor shepherd. Just as he has a responsibility to help the family understand that if it overprotects the alcoholic and allows exploitation, so the minister must explain to the community that if it does the same thing the situation is not helped.

It is an interesting thing to hear a minister preach on the subject that God disciplineth those whom he loveth and then see this same minister running around the community aborting the hand of God's discipline. For example, it is not the pastor's job to secure a job for the alcoholic every time he is fired but to help the employer in his church set up a program of rehabilitation so that the alcoholic may be motivated to recover or accept the consequences of a lost job. I never recommend an alcoholic for a job but I always inform any client who is searching for work that I will most willingly explain to any prospective employer the basic policy under which an alcoholic might be employed so that the conditions are not unjust to either or both parties. In motivating an alcoholic never try to tug at his heartstrings. If at all possible let the boss pluck at the purse strings so that reward and disciplinary action relate directly to what happens.

The same is true in regard to the courts. It is not the parson's job to bail out every church member who becomes incarcerated. Far better for all alcoholics and their family if the minister learned court procedures and how such experiences could be used to motivate the alcoholic. It is still an irony that a harmless public drunkard may end up in jail while a husband can literally destroy a family while firmly exercising what he terms his constitutional right to drink. Jail is the last place on earth we should think of placing an alcoholic. Our present laws do not reflect what is now known about alcoholism as an illness.

A client who had just lost his job after 20 years of using drugs and alcohol was being briefed for admission to the U. S. Public Health Hospital. Trying to comfort the man who got hooked on Terpin Hydrate while combating chronic illness in the Burma Theater in the last great war I stated: "You are not an evil person because of this addiction—you have an illness." He looked at me and stated the whole moral issue involved in alcoholism in one sentence: "I know that I am sick but wouldn't it be wrong if I did not go for treatment?"

No man becomes a chronic alcoholic overnight. The average time is 20 years of untreated, progressive, aided and abetted alcoholism. During this time the alcoholic destroys his health, his family and his economy—that is, if the family and the community permit it to happen. There is much comment today about the unwillingness of the medical profession to treat alcoholics and hospitals to open their doors to the alcoholic

patient. I regret this medical lag but there is a far more serious problem. The chronic alcoholic in the acute stage is a medical emergency but have you ever stopped to think that this medical emergency arises because many persons have flunked their moral responsibility for at least 20 years? This three-way triple immorality between the alcoholic, his family and the community will continue year after year if the disease is permitted to grow to monstrous proportions. We insist on treatment of tuberculosis when discovered. Diabetes requires immediate diet and continued therapy. We keep asking the medical profession to reduce the crisis of withdrawal and then do not have the courage or the honesty to face up to what is happening—to pin down moral responsibility and then stick to a plan of action—in treating alcoholism.

Final Analysis

In the final analysis, pastoral counseling is interpreting moral theology to the patient, the family and the community. Conformity has reached such an irreversible point in our present society that few families have the courage to break with tradition. I constantly deal with families caught in that tension created by the tremendous needs to follow conventional attitudes and methods on one hand or to break with this and openly approach the problem from a new point of view on the other. The one bright spot is that many families are hungry for a new moral interpretation of this family drama.

The community is in much the same position. Basic scientific knowledge of alcohol and alcoholism has not been taught in school, Sunday School or elsewhere except here and there as alcoholism programs reach small segments of society. The unconscious attitude in the minds of most persons is that somehow the church is against alcohol, but most persons continue to drink socially and a percentage of those who do, discover alcohol as the answer to their basic human problem.

Our present society not only needs basic knowledge and information on the subject of alcohol and alcoholism; it is hungry for it. This knowledge and information can be provided by a Council on Alcoholism, state alcoholism programs or the many schools which now offer special courses patterned in some way after the initial Yale-Rutgers School of Alcohol Studies. Personnel directors, ministers, doctors, lawyers, judges, school teachers, Sunday School teachers—all the community persons who deal with people in a professional manner—need to know the nature of alcohol and alcoholism in order that valid information, not misinformation or folklore, be perpetuated. We cannot make a breakthrough until the community is concerned enough to learn and act upon basic knowledge of alcoholism.

Alcoholism is the pastor's largest single pastoral problem from the point of view of the number of persons in a parish who need help. If he is to be an effective pastoral counselor he must also take the lead in arousing the community. If the minister changed the attitude of his church people and gave them adequate education in alcoholism, he would in this manner more than by any other means become a successful pastoral counselor, for those who need his help most of all are not the alcoholics, but those who have normal direct contact with the alcoholic in his home or at work. This is why pastoral counseling must focus on community concern.

DIRECTORY OF OUTPATIENT FACILITIES
for
ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Mike Dechman, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.:* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St., P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 763-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April issue of **Inventory**, go to your community library and make the request.

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